ANGELA M. ANDRICH, M.D.
1800 Blankenship Road, 200
West Linn, Oregon 97068

NEW PATIENT QUESTIONNAIRE
office visit

NAME:_____Date:_____

DOB:_____

What is your current living situation?

Current employment or source of income?

Briefly, what symptoms or concerns have led you to seek a psychiatric evaluation? (your chief complaint)

FOR THE FOLLOWING QUESTIONS, PLEASE CIRCLE ALL THAT APPLY TO YOU RECENTLY:

My mood: sad/depressed irritable/angry too happy/elated numb/detached

I have been sleeping: too much too little not at all just right

My appetite is: increased decreased just right gained weight lost weight

I restrict calories: yes no I binge: yes no I purge: yes no

My sex drive is: increased decreased same as usual

Physically, I feel: slowed down hyperactive just right

My concentration is: decreased same as usual/fine

My thoughts are racing: yes no

I get enjoyment or pleasure in life: yes no

My energy level is: increased decreased just fine

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I feel as though I could conquer the world: yes no

I start projects and don't finish them: yes no

My motivation is decreased: yes no

I feel: helpless hopeless neither

Sometimes I have thoughts of suicide: yes no

I would never harm myself because_____

I have access to guns: yes no

I feel excessively: worthless guilty neither

Sometimes I feel: anxious nervous worried panicky

I have physical symptoms: chest pressure shortness of breath heart palpitations

nausea vomiting headaches dizzyness tense muscles

I hear voices or see visions: yes no

I have special powers or get special messages: yes no

I feel paranoid, like someone is out to get me: yes no

I have a history of being abused, neglected or traumatized: yes no

I have nightmares or flashbacks: yes no

I have thoughts that seem silly or excessive: yes no

I engage in behaviors/rituals such as: counting checking cleaning touching hoarding

Family/friends notice I am not like my old self: yes no

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CIRCLE CURRENT STRESSORS IN YOUR LIFE:

relationships **separation/divorce** **moves** **work**

illness **deaths/losses** **financial** **aging parents**

legal problems **other**_____

_____

Circle the items below if they ARE a part of your lifestyle currently:

well balanced diet	yoga/meditation	diet high in fat/sugar/calories
exercise	massage	social activities
hobbies/interests		dog/cat/other pet
spiritual/religious interests		supplements

Circle items you use below and include the quantity used per day or week:

ALCOHOL	CANNABIS/MARIJUANA
OPIATES/NARCOTICS	STIMULANTS/SPEED
ECSTASY	LSD
CIGARETTES	COFFEE /TEA/ENERGY DRINKS

FOR ALCOHOL USERS, HAVE YOU HAD: DUII BLACKOUTS

IS ANYONE BOTHERING YOU ABOUT HOW MUCH YOU DRINK? YES NO

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PREVIOUS PSYCHIATRIC HISTORY

Any previous psychiatric care or therapy? yes no

Any previous psychiatric hospitalizations (approx dates, locations):

Any previous suicide attempts (approx dates):

Circle any previous psychiatric medications that you have taken in the past:

prozac paxil zoloft celexa lexapro effexor cymbalta remeron

wellbutrin depakote lithium tegretol neurontin trilafon haldol zyprexa

seroquel risperdal geodon abilify ambien trazodone klonopin ativan

xanax ritalin adderall concerta dexedrine lamictal lunesta

other_____

Family Psychiatric History--Any history of the following in biological relatives (please circle all that apply)?

anxiety/panic	depression	bipolar disorder
schizophrenia	obsessive/compulsive disorder	dementia
alcoholism	other addiction	autistic disorder
violent behaviors	suicide attempts	completed suicide

List any psychiatric medications that have helped a biological relative with mental health issues:_____

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MEDICAL HISTORY

LIST DRUG ALLERGIES:_____

HEIGHT:_____**WEIGHT:**_____

NAME OF PRIMARY CARE PHYSICIAN_____

DATE OF LAST PHYSICAL EXAM_____

WOMEN: LAST MAMMOGRAM_____

LIST ALL CURRENT MEDICATIONS/DOSES INCLUDING OVER THE COUNTER MEDS, VITAMINS, MINERALS, HERBAL SUPPLEMENTS, ENERGY DRINKS, ETC.

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING ILLNESSES?

high blood pressure	diabetes	high cholesterol	lung disease
anemia	low vitamin D/B12	thyroid disease	heart attack
heart disease	cancer	chronic pain	seizure disorder
head injury	kidney disease	liver disease	heartburn
headaches	arthritis	fibromyalgia	sleep apnea
snoring	irritable bowel	other	eating disorder
women: heavy/painful/irregular periods			neurological disorder

LIST ANY SURGERIES_____

DOES DIABETES, CANCER, HEART DISEASE OR OTHER ILLNESS RUN IN YOUR FAMILY?

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West Linn, Oregon 97068

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fax: 503-722-5999

Patient Name:_____DOB:_____

Please check the boxes below if you DO or DO NOT have any of the following symptoms:

	Yes	No
Constitutional Symptoms		
Fever	☐	☐
Chills	☐	☐
Weakness	☐	☐
Poor Appetite	☐	☐
Weight Loss/Gain	☐	☐
Eyes		
Blurred Vision	☐	☐
Double Vision	☐	☐
Pain	☐	☐
Glasses	☐	☐
Change in Vision	☐	☐
Allergic/Immunologic		
Hay Fever	☐	☐
Drug Allergies	☐	☐
Neurological		
Tremors	☐	☐
Dizzy Spells	☐	☐
Numbness/Tingling	☐	☐
Frequent or Severe Headaches	☐	☐
Ear/Nose/Throat/Mouth		
Ear Infection	☐	☐
Sore Throat	☐	☐
Sinus Problem	☐	☐
Difficulty Hearing	☐	☐
Earaches	☐	☐
Cardiovascular		
Chest Pain	☐	☐
Varicose Veins	☐	☐
High Blood Pressure	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Swelling of Legs	☐	☐
Use of Oxygen	☐	☐
Gastrointestinal		
Abdominal Pain	☐	☐
Nausea/Vomiting	☐	☐
Indigestion/Heartburn	☐	☐
Diarrhea	☐	☐
Blood in Stool	☐	☐
Ulcers	☐	☐
Jaundice	☐	☐
Constipation	☐	☐

	Yes	No
Skin		
Skin Rash	☐	☐
Lump/Growth on Skin	☐	☐
Boils	☐	☐
Persistent Itch	☐	☐
Change in Skin Color	☐	☐
Musculoskeletal		
Joint Pain	☐	☐
Neck Pain	☐	☐
Sore Muscles	☐	☐
Osteoporosis	☐	☐
Psychiatric		
Memory Loss/Forgetfulness	☐	☐
Depression	☐	☐
Respiratory		
Wheezing	☐	☐
Frequent Cough	☐	☐
Shortness of Breath	☐	☐
Blood in Sputum	☐	☐
Genitourinary		
Urine Retention	☐	☐
Painful Urination	☐	☐
Urinary Frequency	☐	☐
Blood in Urine	☐	☐
Discharge (penile or vaginal)	☐	☐
Hematologic/Lymphatic		
Swollen Glands	☐	☐
Enlarged Lymph Nodes	☐	☐
Blood Clotting Problems	☐	☐
Easy Bruising or Bleeding	☐	☐
Frequent Bleeding from Gums	☐	☐
Anemia	☐	☐
Endocrine		
Excessive/Increased Thirst	☐	☐
Heat/Cold Intolerance	☐	☐
Too Hot/Cold	☐	☐
Tired/Sluggish	☐	☐
GYN (females only)		
Symptomatic Hot Flashes	☐	☐
Symptomatic Vaginal Dryness	☐	☐
Difficulty Sleeping	☐	☐

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SOCIAL HISTORY

Where were you born and raised?

Who raised you?

Any siblings? where are you in birth order?

How were your grades in school?

Highest grade level reached in school?

Any marriages or long term relationships?

Do you have children, step children? ages?

Current employment?

Do you enjoy your work?

Military history?